Community Podiatry Service

Introduction and Background

Diabetes is one of the fastest growing health challenges worldwide and diabetes foot related disease is a common and costly complication of this, however one that is potentially avoidable. The age standardised amputation rate amongst the Waitemata/Auckland region has been identified as being three times higher in males than females at 38.8 per 100,000 population and 13.1 per 100,000 respectively. The lifetime risk of a person with diabetes developing a diabetes foot ulcer (DFU) is 25%. Diabetes is the leading cause of lower limb amputations, and in New Zealand being indigenous Māori is considered an independent risk factor due to Māori having unexplained higher rates of diabetes related lower limb amputation (DRLLA). Early recognition, assessment and rapid referral to specialist diabetic foot secondary services can prevent DRLLA.

The majority of DFUs and DRLLAs are avoidable through annual foot screening and the identification of risk factors. In New Zealand foot screening should be undertaken in primary care at least annually as part of a person's diabetes annual review.

Foot risk is triaged as **low**, **moderate**, **high**, **in-remission** and **active**, based on the Scottish risk stratification system. Please see Diabetes Foot Screening Risk Stratification Tool and the Auckland PHO Foot Screening Referral Pathway

Aim of the Auckland PHO Community Podiatry Service

To reduce disease progression by providing an accessible community podiatry service to our enrolled and eligible population by improving the foot health status of patients with high-risk diabetes foot-related pathologies to achieve equitable outcomes.

Equity

Auckland PHO Community Podiatry Service ensures:

- Patients with a moderate to high-risk foot disease have access to podiatry services
- The provision of podiatry services within local communities, at locations accessible to patients. This includes the provision of services that are accessible and culturally acceptable for Māori and Pacific peoples.
- Practices can work in partnership with their patients and facilitate an affordable/free service to reduce complications of diabetes and foot disease.

Patient Eligibility

Patients must be enrolled in an Auckland PHO practice and meet the following criteria to receive funded community podiatry services:

1) Diagnosis of Type 1 or Type 2 Diabetes and
2) Have moderate (2) or high (3) risk diabetes foot disease – classified at the time of the patient's diabetes annual review with a risk category of moderate to high risk using the Diabetes Foot Screening and Risk Stratification.

- **Moderate foot disease** includes any **one** of the following:
  - Loss of sensation *(assessed via 10gm monofilament or 'touch toe' test)*
  - Peripheral arterial disease
  - Significant foot deformity
  - Significant callus
  - Pre-ulcerative lesion
  - eGFR <15 (CKD stage 5)

Both the 10gm monofilament test and the Touch Toe Test can be reliably used for screening for loss of protective sensation caused by distal peripheral neuropathy that is a complication of diabetes. The calculation to say there is loss of protective sensation automatically changes when you select the test that you are going to carry out.

High Risk foot Disease includes:
Two or **more** of the following:

- Loss of sensation
- Peripheral arterial disease
- Significant callus
- Significant foot deformity
- Pre-ulcerative lesion
- eGFR <15 (CKD stage 5)
- Māori ethnicity

In-remission (One of the following):

- Previous amputation
- Previous ulceration
- Consolidated Charcot foot

Note: The in-remission group have higher morbidity and mortality than all other groups, even those with an active foot problem. They also have at least a 50% chance of re-ulcerating within 12months. They require close monitoring and may need to be managed by the Secondary Diabetes Podiatry Foot Clinic.

Patients with the following conditions are not eligible for this service are:

- **gestational diabetes**
- **pre-diabetes**
- **low risk of developing diabetes related foot disease**
- **require toenail cutting only**

Referral Process

Low Risk – Refer to private Podiatry. If there are financial issues for the patient, consider using the Practice's 'Discretionary Funding Pool' option.

Moderate to High risk - A referral to a community podiatrist can be generated via a Mōhio Podiatry referral form by a practice nurse or GP. The Auckland PHO Podiatry Service Coordinator will manage the referral and contact the patient to discuss a suitable location for the contracted podiatry service to take place.

Active Risk – Admit to hospital and refer to Healthpathways for updated advice. All patients with acutely infected feet should be referred to vascular surgery.

POAC does not fund intravenous antibiotics for these patients unless endorsed by a named specialist.

If active ulceration, request non-acute diabetes assessment, and select podiatry on the e-referral form, marking the request as urgent.

Note: Practice Nurses must be competent in diabetes foot screening in order to refer to the community podiatry service.

Community Podiatry Service

- Services are delivered by contracted podiatrists who have a current annual practicing certificate and have a minimum of 2 years' experience working with the diabetic foot.
- Podiatrists demonstrate that they have the necessary equipment to complete a full assessment.
- Appointment duration is appropriate for level of assessment required. It is expected that a first assessment (FA) appointment are approximately 45 minutes and follow ups (FU) are approximately 30 minutes.
- The Podiatrist will provide a package of care to the patient that is based on patient individual needs. Each person will receive a year of care from the time they are referred to the community podiatry services having been identified as being at moderate or high risk of developing diabetic foot disease. If the patient's foot condition heals to a low risk foot category, the podiatrist will transfer the patient back to the practice with a summary on how to care for the person's feet.
- The initial assessment will include:
  - General health and diabetes assessment
  - Vascular assessment with Doppler
  - Neurological assessment
  - Footwear assessment
  - Dermatological assessment
  - Treatment of foot conditions for people with moderate or high-risk feet as clinically appropriate and the development of a treatment plan for the year
  - Arrangement of follow up appointment if required
- The podiatrist will inform the practice about the treatment being provided, length of the treatment plan and when the patient exits the service. A written report will be provided within three weeks of the completion of service with any instructions for the GP/nurse to follow-up.
- Telehealth can be provided by podiatrists for urgent cases of patients already under their care during level 3 and 4 lockdowns longer than 7 days duration. The usual referral pathways still apply, and all active foot problems should be referred to the secondary services Specialist MDT foot team. Telehealth is provided as defined by the Podiatrists Board of New Zealand and follows the Board's recommended telehealth standards.

Funding

The practice can charge the usual co-payment to see the patient with diabetes or claim the Diabetes Year of Care claim ($50), however the podiatry service is free to the patient.

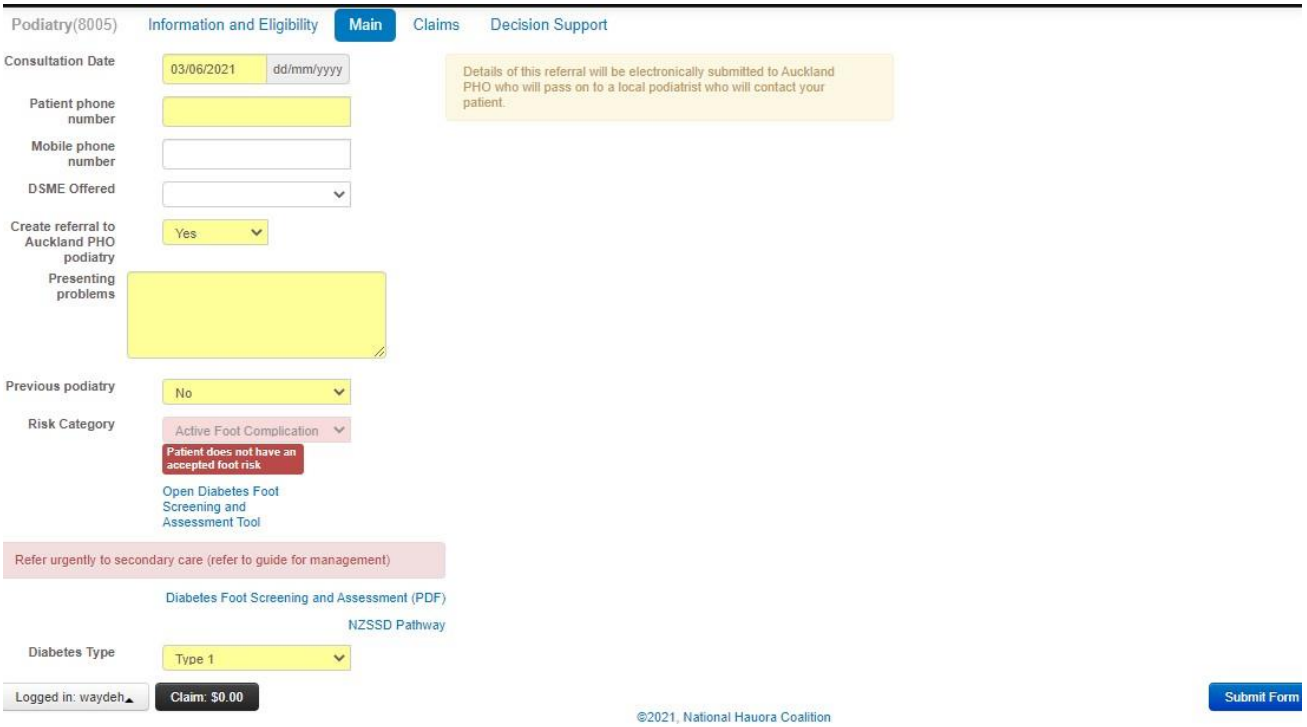
All eligible patients are able to have one episode of care (up to four sessions) per year.

Patients can be re-referred by a GP or Practice Nurse after one year from the date of their initial referral.

If the podiatrist requires additional sessions, they will contact the Podiatry Co-ordinator at Auckland PHO who will consult/notify the GP of the need for additional treatment.

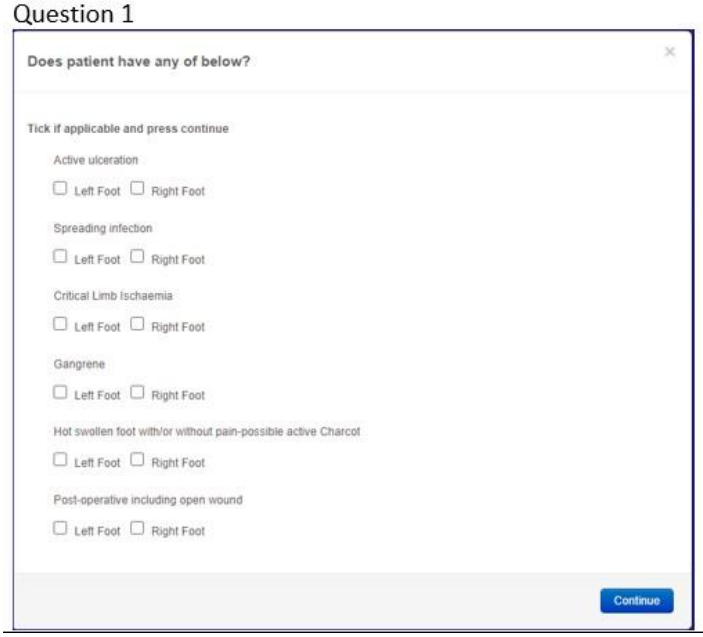
Mōhio Podiatry Referral Form

The screenshots below as examples of the Mōhio referral form and risk stratification questions that appear when the "Diabetes Screening and Assessment Tool" is opened.



Diabetes Foot Screening and Assessment Tool

Question 1



Question 2

Question 3